Guiding Principles for Serious Accident Reporting

A. All serious accidents will be professionally investigated to determine causes and corrective actions.
B. Determine NEW causes for new corrective actions.
C. Cause determinations for prevention, FACHQ: Navy-wide guidance, process or design changes.
D. Simple accidents, simple investigations.
E. Team leader needs to have investigative experience and be knowledgeable in problem solving techniques.
F. Determine what allowed accident to happen.

1. The present CNO policy for Navy civilian mishaps was officially distributed via OPNAVINST 5100.23D. The present NAVFACHQ policy for contractor mishaps was officially distributed via CO NAVFACENGCOM ltr Ser 1515 of 18 Sept 1995 and CO NAVFACENGCOM ltr Ser 1510 of 29 August 1995. (Provided change 2 to NAVFACINST 5100.11H)
2. NAVFAC requires EFD/EFA/Independent OICC/PWC/NFESC to investigate their serious contractor accidents.
3. The process and logic are the same as outlined in OPNAVINST 5100.23(series). Independent investigations shall be lead by Safety/Health Manager.
4. The mishap report shall be signed out by the lead investigator and sent thru channels to Safety Center for civilian accidents, but stops at NAVFACHQ for contractor accidents. (NAVFAC (SF) keeps the official "record copy" of the investigation report for contractor mishaps.)
5. All EFA reports shall be sent via the parent EFD.
6. JAGMAN reports (Litigation Reports) should be completed and tracked, sent via FACHQ to Navy JAG. (See para 3 & 4 of RADM Moeller MSG of 16 April 97)
7. JAGMANs should not make recommendations.
8. Contractor mishap reports should identify causal factor and the command should track corrective actions to ensure they are completed.
9. The submission time limit is 45 days for all accident reports.
10. Accident reports should NOT be written in JAGMAN format, it confuses readers, Navy JAG and FOIA folks.
11. Executive Summary. From the Key West fatal investigation report, an executive summary of 2-3 pages was prepared, the report was enclosure (1) and the FAIR document was enclosure (2). (We briefed the accident at CNO level and they liked the executive summary and tasked the Safety Center to change the Navy process to coincide.)
12. STEP technique is preferred to assure all actors are identified.

REPORTS

1. Contractor mishap reports shall be forwarded by the lead investigator to NAVFACHQ via the Chain of Command. The responsible EFD/EFA/Independent OICC/PWC/NFESC Commander/Commanding Officer shall review and endorse the report. EFAs shall submit reports via their parent command. The final report should not exceed 30 pages and include the following:

   (a) Executive Summary
   (b) Sequence of Events
   (c) Discussion and Findings (Facts)
   (d) Conclusions
   (e) Recommendations for Corrective Actions
   (f) The “Contractor Significant Incident Report (CSIR-1)” Form shall be included as an attachment.

The Commander/Commanding Officer shall forward the report, with his endorsement, to NAVFACHQ, with a copy to the Facilities Safety and Health Support Office, within 45 days of the mishap.

A summary of facts and recommendations shall be distributed to cognizant departments within the reporting activity. As appropriate, a “lessons learned” shall be prepared and forwarded to the Facilities Safety and Health Support Office using the format in Appendix D of NAVFACINST 5100.11 (series) not later than 45 days after an incident.

2. Navy civilian mishap reports shall be completed and forwarded by the lead investigator to the Naval Safety Center via the Chain of Command as outlined in OPNAVINST 5100.23(series).

Copies of the executive summary (only) shall be provided to NAVFACHQ and other appropriate parties upon completion of the final report. Report format is same as above except the CSIR-1 is replaced by the SR form.